Jefferson County Public Health Department

Administrative Office: 214 South Main- P O Box 872, Boulder, MT 59632
Phone (406) 225-4007 or (406) 287-3249
Fax (406) 225-4108

Public Health
Prevent. Promote. Protect.

Client Referral

Date of Referral: ____/____/_____

1. Client Name: _____ / _____ / _____
Last *First* *M.I.*

Gender: M____ F____

____/____/_____
DOB: *MM / DD / Year*

Address:

Hm Ph #: ( )

Cell #: ( )

City: **State:**

Zip:

Medicaid ID #:

2. Referral To: _____ Ph #:( ) _____ Fax #:( ) _____
Name

Address: _____ City: _____ State: _____ Zip: _____

3. Referred By: _____ Ph #:( ) _____ Fax #:( ) _____
Name

Address: _____ City: _____ State: _____ Zip: _____

4. Reason for Referral: _____

_____

_____

_____

_____

_____

_____

_____ **Sig:** _____

5. Authorization: I, (_____) authorize (_____), to release this
[Client / Guardian Name] *[Service Provider's Name]*

information to (_____) . The information is to be used to assist me in
[Care Coordination Providers name]

monitoring and coordinating my health care and social service needs.

Signature of client or guardian: _____ Date: _____

6. Service Providers Reply: **(Summary of findings, diagnosis, recommendations, Comments)** **OR SEE ATTACHED** ☐

_____

_____

_____

_____

_____

_____

_____ Sig: _____ Date: _____

6. Follow-up dates/status: _____

_____